

Smoking Cessation for Persons with Mental Illnesses

A Toolkit for Mental Health Providers



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Funding for this project was provided by:

Tobacco Disparities Initiatives of the State Tobacco Education and Prevention Partnership (STEPP), Colorado Department of Public Health and the Environment

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Why is a smoking cessation toolkit for persons with mental illnesses needed?

They need to quit.

Consumers need to be alive to “recover” from mental illnesses. Smoking cessation is a key component of consumer-driven, individualized treatment planning.

They want to quit.

People with mental illnesses want to quit smoking and want information about cessation services and resources. (Morris et al, 2006)

They can quit.

People with mental illnesses can successfully quit using tobacco. (Evins et al., 2005; George et al., 2002). Significant evidence shows that smoking cessation strategies work.

Note: Throughout this toolkit the terms “tobacco use” and “smoking” are used interchangeably. Although we do not specifically address spit-tobacco use, the toolkit is generally applicable to spit-tobacco users.

“I’d love to quit – I just don’t know how.”

– John, age 45

Alarming Statistics

Approximately 7.7 percent of Colorado's adult population has a major mental illness.¹

Forty-one percent of these individuals use tobacco. The prevalence of smoking among people with mental illnesses is startling.

By diagnosis:

Major depression	45-50 percent
Bipolar mood disorder	50-70 percent
Schizophrenia	70-90 percent

Americans with mental illnesses represent an estimated 44.3 percent of the tobacco market.²

Americans with mental illnesses are nicotine dependent at rates that are two to three times higher than the general population.³

Because people with mental illnesses use tobacco at greater rates, they suffer greater smoking-related medical illnesses and mortality.⁴

About this toolkit

Who is this toolkit for?

This toolkit was developed for a broad continuum of mental health providers. Materials are intended for direct providers, as well as administrators and behavioral health organizations.

How do I use this toolkit?

The toolkit contains a variety of information and step-by-step instruction about:

- Low burden means of assessing readiness to quit
- Possible treatments
- Referral to Colorado community resources

1] Morris et al., 2006

2] Grant et al., 2004, Lasser et al., 2000

3] Grant et al., 2004, Lasser et al., 2000

4] Grant et al., 2004

Quick Facts

Mental Illnesses and Tobacco Use

- 7.1% of the U.S. population has a psychiatric illness; however, this population consumes over 34.2% of all cigarettes. (Grant et al., 2004)
- In the U.S., persons with mental illnesses represent an estimated 44.3% of the tobacco market and are nicotine dependent at rates that are 2-3 times higher than the general population. (Grant et al., 2004; Lasser, 2000)
- In Colorado, approximately 7.7% of the adult population has a major mental illness and 41% of these individuals use tobacco. (Giese et al., 2003)
- Smoking cessation is a key component of consumer-driven, individualized treatment planning. (Morris et al., 2006)
- Persons with mental illnesses want to quit smoking and want information on cessation services and resources. (Morris et al., 2006)
- Persons with mental illnesses can successfully quit using tobacco. (Evins et al., 2005; George et al., 2002)
- Smoking quit rates for individuals with psychiatric illness are NOT significantly lower than the general population. (el-Guebaly et al., 2002)
- Because persons with mental illnesses use tobacco at greater rates, they suffer greater smoking-related medical illnesses and mortality. (Grant et al., 2004)

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El-Guebaly N, Cathcart J, Currie S et al (2002). Smoking cessation approaches for persons with mental illness or addictive disorders. *Psychiatric Services*, 53(9): 1166-1170.

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Tobacco Use and Mental Illness

- 1 Smoking and Mental Illness:
 - Biological Predispositions
 - Psychological Considerations
 - Social Considerations
 - Stigma
- 2 Specific Mental Disorders:
 - Depression
 - Schizophrenia
 - Other Disorders
- 3 Tobacco Industry Targeting

Tobacco use and mental illness



Smoking and mental illnesses: nicotine effects and other considerations

People with mental illnesses:

- use tobacco at higher rates
- are less likely to succeed at cessation attempts
- access general medical services and other community resources relatively infrequently
- struggle with stigma on several levels
- generally experience a greater burden of morbidity and mortality than the overall population.

Why do they smoke more?

Researchers believe that a combination of biological, psychological and social factors contribute to increased tobacco use among persons with mental illnesses.

Biological predisposition

Persons with mental illnesses have unique neurobiological features that may increase their tendency to use nicotine, make it more difficult to quit and complicate withdrawal symptoms.

Nicotine affects the actions of neurotransmitters (e.g. dopamine). For example, people with schizophrenia who use tobacco may experience less negative symptoms (lack of motivation, drive and energy).

Nicotine enhances concentration, information processing and learning. (This is especially important for persons with psychotic disorders for whom cognitive dysfunction may be a part of their illness or a side effect of antipsychotic medications).

Other biological factors include nicotine's positive effects on mood, feelings of pleasure and enjoyment.

Some evidence suggests that smoking is associated with a reduced risk of antipsychotic-induced Parkinsonism.

Psychological considerations

- Tobacco use may temporarily relieve feelings of tension and anxiety and is often used to cope with stress.
- People develop a daily routine of smoking.

Social considerations

- People may smoke to feel “part of a group.”
- Smoking is often associated with social activities.
- Persons with mental illnesses may not have a lot of activities to keep them busy. When they’re bored, they may smoke more.
- The site of a social activity may support tobacco use.

Stigma

- Providers often think that people with mental illnesses are unable to quit smoking.
- Symptom management often takes precedence over preventive health measures.

Stress is a big trigger for me. I don't know how to deal with stress.

– Cathi, age 32

Specific mental disorders

What are some considerations for smoking cessation in regard to specific mental disorders?

Depression

Among patients seeking smoking cessation treatment, 25-40 percent have a history of major depression and many have minor dysthymic symptoms.

Depression has been shown to predict poorer smoking cessation rates. Consider starting or restarting psychotherapy or pharmacotherapy for depression in patients who state that depression intensified with cessation or that cessation caused depression.

Cognitive behavioral therapy for depression and antidepressants has been found to improve smoking cessation rates in those with a history of depression or symptoms of depression.

For a smoker with a history of depression currently taking antidepressant medication, it is important to note that some antidepressant levels will increase with smoking cessation.

What I did to keep from craving cigarettes for a while is just to keep busy, being with people, and talking and playing games and working and things like that. That's what helped me.

– Robert, age 43

Schizophrenia

Persons with schizophrenia who smoke may be less interested in tobacco cessation, making strategies to enhance motivation to quit especially important.

When mental health consumers with schizophrenia do try to stop, many are unsuccessful; thus, intensive treatments are appropriate even with early attempts.

The high prevalence of alcohol and illicit drug abuse in consumers with schizophrenia can interfere with smoking cessation.

The blood levels of some antipsychotics can increase dramatically with cessation. Nicotine withdrawal can mimic the akathisia, depression, difficulty concentrating and insomnia seen in consumers with schizophrenia.

Other psychiatric disorders

There is insufficient information to make specific recommendations about tailoring treatment of smoking cessation to the needs of smokers with other psychiatric disorders.

In general, when mental health consumers make an attempt at smoking cessation, they should be followed closely to monitor for more severe nicotine withdrawal, exacerbation of their psychiatric disorder and possible side effects due to cessation-induced increases in medication levels.

Methylphenidate (Ritalin) and d-amphetamine (Dexedrine), stimulants commonly prescribed for behavioral problems associated with attention deficit hyperactivity disorder (ADHD) increase rates of smoking and the reinforcing effects of smoking. Methylphenidate and d-amphetamine use in early life leads to increased odds of daily smoking later in life.

Tobacco industry targeting

By 1977, smokers were becoming a “downscale market.” RJ Reynolds noted that less educated, lower income, minority populations were more impressionable/susceptible to marketing and advertising. Tobacco companies began targeting these populations. **Free cigarettes were distributed to homeless shelters, mental hospitals and homeless service organizations.** Cigarettes were purchased for the mentally ill and homeless so that consumers would smoke “clean” cigarettes, not dirty cigarette butts.

The tobacco industry has targeted psychiatric hospitals for sales promotions and giveaways. They have made financial contributions to homeless veteran organizations, using relationships to advance their political agenda.

I’ve been schizophrenic since I was 14. I was told more or less when I went to the hospitals that cigarettes help control certain areas in my brain and the way we function out in society. I more or less became more of a smoker because I was told it would help me with my illness. I was taught more about it helping my illness than I was about cancer and stuff like that.

– Marc, age 24

Assessment and Intervention Planning

- 1 Readiness to Quit and Stages of Change:
 - Stages of Change
 - The 5 A's (Flowchart, Actions and Strategies)
 - The 5 R's (Addressing Tobacco Cessation for Tobacco Users Unwilling to Quit)
- 2 Cultural Considerations:
 - Recommendations for Mental Health Clinicians
 - Resources

Assessment and intervention planning



Readiness to quit and stages of change

The Stages of Change Model (also known as the Transtheoretical Model) illustrated below is useful in recognizing that nicotine dependence is a chronic, relapsing disorder with most tobacco users in the general population requiring five to seven attempts before they finally quit for good. Many patients do not realize that it usually takes several attempts to stop using tobacco and will need motivation to attempt to quit if they have been unsuccessful in the past. It is useful to think of tobacco cessation as a process rather than an event.

Once a person has been identified as a tobacco user, his or her readiness to quit can be determined. This is important because tobacco users who are not considering quitting appear to need different interventions than those who are ambivalent about quitting or those presently interested in quitting. Tobacco users in the Precontemplation stage (not considering quitting) can be moved to the Contemplation stage by asking consumers to consider the negative consequences of tobacco use for them and the advantages of tobacco cessation (this information has to be personalized). It is worthwhile to actively encourage quitting and offer support and treatment as well as conveying the message that persons with mental illnesses can successfully quit using tobacco.

Stages of change

- Precontemplation: No change is intended in the foreseeable future. The individual is not considering quitting.
- Contemplation: The individual is not prepared to quit at present, but intends to do so in the next six months.
- Preparation: The individual is actively considering quitting in the immediate future or within the next month.
- Action: The individual is making overt attempts to quit. However, quitting has not been in effect for longer than six months.
- Maintenance: The individual has quit for longer than six months.

The 5 A's:

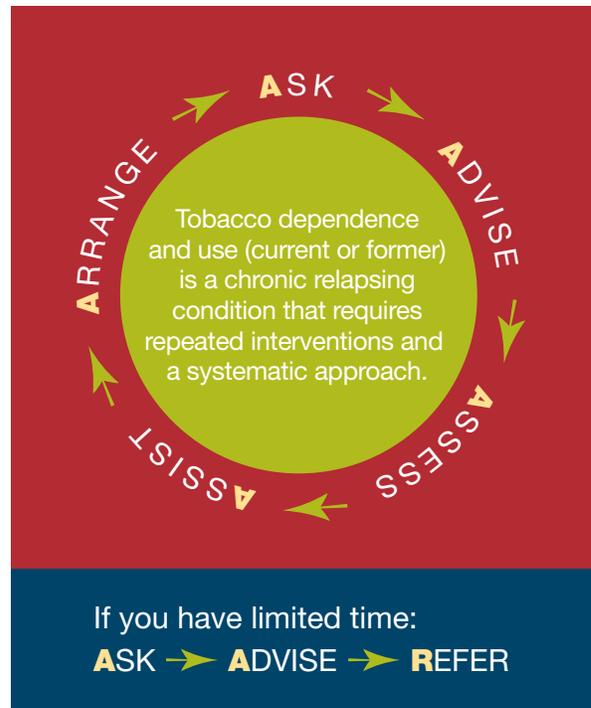
Ask, Advise, Assess, Assist and Arrange

The U.S. Public Health Service Clinical Practice Guideline: *Treating Tobacco Use and Dependence* provides healthcare clinicians a strategy for smoking cessation treatment that is built around the “5 A's” (Ask, Advise, Assess, Assist and Arrange). Knowing that providers have many competing demands, the 5 A's were created to keep steps simple.

On the following pages you will find a summary of these easily implemented steps.

The Guideline recommends that all people entering a healthcare setting should be **asked** about their tobacco use status and that this status should be documented. Providers should **advise** all tobacco users to quit and then **assess** their willingness to make a quit attempt. Persons who are ready to make a quit attempt should be **assisted** in the effort. Follow up should then be **arranged** to determine the success of quit attempts.

The full 5 A's model is most appropriate for agencies and organizations that have tobacco cessation medications and/or behavioral services available for consumers. For agencies and organizations that do not have tobacco cessation services readily available, we recommend the use of the first two A's (**ask** and **advise**) and then **refer** to available community services. The full 5 A's model, as well as the abbreviated ask-advise-refer model are presented in the flowchart and tables at the back of this book.



Actions and Strategies for Mental Health Providers to Help Consumers Quit Smoking

ASK	
Action	Strategies for Implementation
<p>Ask every consumer at every visit, including hospital admissions, if they smoke.</p>	<p>Within your practice, systematically identify all tobacco users at every visit.</p> <p>Establish an office system to consistently identify tobacco use status at every visit. (See clinic example at end of this section.)</p> <p>Determine what form of tobacco is used.</p> <p>Determine frequency of use.</p> <p>Determine tobacco use status.</p> <p>Make note of consumers exposed to secondhand smoke.</p>

ADVISE	
Action	Strategies for Implementation
<p>In a clear, strong and personalized manner, advise every tobacco user to quit.</p>	<p>Clear: “As your clinician, I want to provide you with some education about tobacco use and encourage you to consider quitting today.”</p> <p>Strong: “As your clinician, I need you to know that quitting smoking is the most important thing you can do to protect your health now and in the future. The clinic staff and I will help you.”</p> <p>Personalized: Tie tobacco use to current health/illness, its social and economic costs, motivation level/readiness to quit, and/or the impact of tobacco use on children and others in the household.</p> <p>See patient educational brochure at back of this manual.</p>
<p>Be mindful to advise in a non-judgmental manner.</p>	

REFER	
Action	Strategies for Implementation
<p>For consumers interested in quitting.</p>	<p>Provide information on local smoking cessation resources. You may find local resources at http://www.co.quitnet.com/libraries/programs/.</p> <p>Use proactive referral if available: Request written consumer permission to fax their contact information to the Colorado QuitLine or other program. Inform the patient the cessation program staff will contact them.</p> <p>Document the referral.</p> <p>See Colorado QuitLine fax referral form at end of this section.</p>

ASSESS	
Action	Strategies for Implementation
<p>Assess willingness to make a quit attempt within the next 30 days.</p> <p>Determine with the patient the costs and benefits of smoking for him or her.</p> <p>Determine where the patient is in terms of the readiness to change model.</p>	<p>Assess readiness for change. Go to p.7 to learn how to assess readiness for change.</p> <p>If the consumer is ready to quit, proceed to Assist (below) and/or arrange for more intensive services to help with the quitting process.</p> <p>If the consumer will participate in an intensive treatment, deliver such a treatment or refer to an intensive intervention (Arrange).</p> <p>If the consumer isn't ready to quit, don't give up. Providers can give effective motivational interventions that keep consumers thinking about quitting. Conduct a motivational intervention that helps consumers identify quitting as personally relevant and repeat motivational interventions at every visit.</p> <p>For addressing tobacco cessation with tobacco users unwilling to quit, please proceed to the 5 R's on page 12.</p>
<p>Assess past quit attempts and past/current psychiatric symptoms for consumers wanting to quit.</p>	<p>For the consumer who is willing to quit:</p> <p>Obtain a smoking history and assess experience with previous quit attempts:</p> <ul style="list-style-type: none"> • Reasons for quitting. • Any change in psychiatric functioning when he or she tried to stop? • Cause of relapse (was this due to withdrawal symptoms or increased psychiatric symptoms?) • How long did he or she remain abstinent? • Prior treatment in terms of type, adequacy (dose, duration), compliance and consumer's perception of effectiveness. • Expectations about future attempts and treatments. <p>Determine whether there are any psychiatric reasons for concern about whether this is the best time for cessation:</p> <ul style="list-style-type: none"> • Is the consumer about to undergo a new therapy? • Is the consumer presently in crisis, or is there a problem that is so pressing that time is better spent on this problem than on cessation at this visit? • What is the likelihood that cessation would worsen the non-nicotine psychiatric disorder? And can that possibility be diminished with frequent monitoring, use of nicotine replacement therapy or other therapies? • What is the consumer's ability to mobilize coping skills to deal with cessation? If the coping skills are low, would the consumer benefit from individual or group behavior therapy? • Is the consumer highly nicotine dependent or does the consumer have a history of relapse due to withdrawal symptoms or increased psychiatric symptoms? If so, which medication might be of help? <p>Increasing readiness/motivation: If a consumer with psychiatric illness is not ready to make a quit attempt, enhance motivation and deal with anticipated barriers to cessation.</p> <ul style="list-style-type: none"> • Use problem solving strategies. • Increase monitoring of tobacco use. • Employ behavioral therapy and/or nicotine replacement therapy. • Address fears of withdrawal symptoms or of worsening psychiatric problems.

ASSIST

Action	Strategies for Implementation
Help the consumer with a quit plan.	<p>Set a quit date, ideally within two weeks.</p> <p>Tell family, friends and coworkers about quitting and request understanding and support.</p> <p>Anticipate triggers or challenges to planned quit attempt, particularly during the critical first few weeks. These include nicotine withdrawal symptoms. Discuss how the consumer will successfully overcome these triggers or challenges.</p> <p>Remove tobacco products from the environment. Prior to quitting, consumer should avoid smoking in places where they spend a lot of time (e.g. work, home, car).</p> <p>For consumers with cognitive difficulties (e.g. memory or attention deficits) due to mental illness, have them write down their quit plan, so they can refer to it later.</p>
Recommend use of approved nicotine replacement therapy (NRT) and/or counseling	<p>Recommend the use of NRT medications to increase cessation success.</p> <p>Discuss options for addressing behavioral changes (e.g. cessation classes, individual counseling, telephone coaching from the Colorado QuitLine)</p> <p>Encourage patients who are ready to quit that their decision is a positive step.</p>

ARRANGE

Action	Strategies for Implementation
Schedule follow-up contact.	<p>Timing. Follow up contact should occur soon after the quit date, preferably within the first week. A second follow-up contact is recommended within the first month. Schedule further follow-up contacts as needed.</p> <p>Actions during follow-up contact:</p> <p>Congratulate success!</p> <p>If the consumer has relapsed, review the circumstances and elicit recommitment to total abstinence.</p> <ul style="list-style-type: none"> • Remind patient that a lapse can be used as a learning experience. • Identify problems already encountered and anticipate challenges in the immediate future. • Assess NRT use and problems. • Consider use or referral to more intensive treatment. • Give positive feedback about the patient's attempts to quit. <p>Individuals often cut down substantially on their tobacco use before quitting, and this harm reduction needs to be recognized and congratulated.</p>

The 5 R's: Addressing Tobacco Cessation for the Tobacco User Unwilling to Quit

(From Treating Tobacco Use and Dependence. Quick Reference Guide for Clinicians, October 2000. U.S. Public Health Service. www.surgeongeneral.gov/tobacco/tobaqrg.htm)

The “5 R's” Relevance, Risks, Rewards, Roadblocks and Repetition, are designed to motivate smokers who are unwilling to quit at this time.

Smokers may be unwilling to quit due to misinformation, concern about the effects of quitting or demoralization because of previous unsuccessful quit attempts. Therefore, after asking about tobacco use, advising the smoker to quit and assessing the willingness of the smoker to quit, it is important to provide the “5 R's” motivational intervention.

Relevance

Encourage the consumer to indicate why quitting is personally relevant, as specifically as possible. Motivational information has the greatest impact if it is relevant to a consumer's medical status or risk, family or social situation (e.g., having children in the home), health concerns, age, gender and other important patient characteristics (e.g., prior quitting experience, personal barriers to cessation).

Risks

Ask the consumer to identify potential negative consequences of tobacco use. Suggest and highlight those that seem most relevant to them. Emphasize that smoking low-tar/ low-nicotine cigarettes or use of other forms of tobacco (e.g., smokeless tobacco, cigars and pipes) will not eliminate these risks.

Examples of risks are:

- Acute risks: Shortness of breath, exacerbation of asthma, harm to pregnancy, impotence, infertility and increased serum carbon monoxide.
- Long term risks: Heart attacks and strokes, lung and other cancers (larynx, oral cavity, pharynx, esophagus, pancreas, bladder, cervix), chronic obstructive pulmonary diseases (chronic bronchitis and emphysema), long term disability and need for extended care.
- Environmental risks: Increased risk of lung cancer and heart disease in spouses; higher rates of smoking in children of tobacco users; increased risk for low birth weight, Sudden Infant Death Syndrome, asthma, middle ear disease and respiratory infections in children of smokers.

Every time I need a pack of cigarettes, that's taking money out of my pocket. You can see everybody around here, people that aren't smoking, look how much money they have. People that are smoking are pretty much broke. If I could quit smoking, I'd have more money to spend.

– James, age 37

Well, the first thing is you have to decide is that you're really committed to doing it and then you try over and over and over until you finally get there, and eventually you get there. But it takes a lot of time and it's not easy.

– Sandy, age 37

Rewards

Ask the consumer to identify potential benefits of stopping tobacco use. Suggest and highlight those that seem most relevant to the consumer.

Examples of rewards follow:

- Improved health
- Food tastes better
- Improved sense of smell
- Money saved
- Better self image
- Home, car, clothing, breath smell better
- No more worrying about quitting
- Set a good example for children
- Have healthier babies and children
- No more worrying about exposing others to smoke
- Feel better physically
- Perform better in physical activities
- Reduce wrinkling/aging of skin

Roadblocks

Ask the consumer to identify impediments to quitting and note elements of treatment (problem solving, medications) that could address barriers.

Typical barriers might include:

- Withdrawal symptoms
- Fear of failure
- Weight gain
- Lack of support
- Depression
- Enjoyment of tobacco

Repetition

Repeat motivational interventions every time an unmotivated consumer visits the clinic setting. Tobacco users who have failed in previous quit attempts should be told that most people make repeated quit attempts before they are successful.

Cultural Considerations

Cultural issues should also be considered for those individuals of diverse racial and ethnic backgrounds as tobacco cessation assessment and services are offered.

Recommendations

Key findings from the Surgeon General's report: (1998 Surgeon General's Report, Tobacco Use Among U.S. Racial/Ethnic Minority Groups)

In the four racial/ethnic groups studied (African American, American Indian/Alaska Native, Asian American/Pacific Islander and Hispanic), African American men bear one of the greatest health burdens, with death rates from lung cancer that are 50 percent higher than those of Caucasian men.

Rates of tobacco related cancers (other than lung cancer) vary widely among members of racial/ethnic groups. They are particularly high among African American men.

Tobacco use among adolescents from racial and ethnic minority groups has begun to increase rapidly, threatening to reverse the progress made against lung cancer among adults in these minority groups. Cigarette smoking among African American teens has increased 80 percent over the last six years – three times as fast as among white teens.

The high level of tobacco product advertising in racial/ethnic publications is problematic because the editors and publishers of these publications may limit the level of tobacco use prevention and health promotion information included in their publications.

Recommendations for Mental Health Clinicians

When working with persons with mental illnesses who are also of diverse racial/ethnic backgrounds, the mental health clinician should:

- Ask, Advise, Assist and/or Refer all patients with regard to tobacco cessation. There is a critical need to deliver effective tobacco dependence education and interventions to ethnic and racial minorities with mental illnesses.
- Use cessation interventions that have been effective for persons with mental illnesses (e.g. NRT or bupropion in combination with individual or group counseling that employs motivational interviewing or cognitive-behavioral strategies). A variety of smoking cessation interventions (including screening, clinician advice, self-help materials and the nicotine patch) have been proven effective for tobacco cessation in minority populations.
- Be culturally appropriate, reflecting the targeted racial/ethnic groups' cultural values. This may increase the smoker's acceptance of treatment.
- Convey cessation counseling or self-help materials in a language understood by the smoker.

Resources

For more information about tobacco use and intervention for racial/ethnic populations in Colorado, please see the following online resources:

Colorado Tobacco Disparities Strategic Planning Working Group: <http://ctdsp.amc.org/>

Colorado State State Tobacco Education and Prevention (STEPP): <http://steppcolorado.com>

Colorado Minority Health Forum for Information on Reducing Health Disparities in Colorado:
<http://www.coloradominorityhealthforum.org/>

Example for Clinic Screening for Tobacco Use

From the U.S. Department of Health & Human Services
<http://www.surgeongeneral.gov/tobacco/tobaqrg.pdf>

ACTION	STRATEGIES for IMPLEMENTATION
Implement an office-wide system that ensures that, for every patient at every clinic visit, tobacco-use status is queried and documented.	Expand vital signs to include tobacco use or use an alternative universal identification system.
<p>VITAL SIGNS</p> <p>Blood Pressure: _____</p> <p>Pulse: _____ Weight: _____</p> <p>Temperature: _____ Respiratory Rate: _____</p> <p>Tobacco Use (circle one): Current Former Never</p>	

- Repeated assessment is not necessary in the case of the adult who has never used tobacco or has not used tobacco for many years, and for whom this information is clearly documented in the medical record.

- Alternatives to expanding the vital signs are to place tobacco-use status stickers on all patient charts or to indicate tobacco-use status using electronic medical records or computer reminder systems.



Colorado QuitLine Referral Form

1.800.QUIT.NOW (1-800-784-8669)

FAX: 800-261-6259

Referring Provider (stamp/label/write in)

Name _____

Clinic/Facility _____

Address _____

City/State/Zip _____

Phone # _____

Fax #* _____

*REQUIRED TO RECEIVE CONFIRMATION OF REFERRAL

Patient Information

Name _____

Address _____

City/State/Zip _____

Phone # _____ DOB _____

Best time and day to call _____

Do you need TTY? **Yes No**

May we leave a message? **Yes No**

Participant Consent for Release of Information

Authorization to Release Information (reflects the requirements of 45 C.F.R. §164.508 August 14, 2002)

I, _____ (Participant name), give permission to my health care provider to release my name, phone number, and date of birth to the Colorado QuitLine (800-QUIT-NOW) quit smoking/tobacco program at National Jewish Medical and Research Center (contractor for the Colorado QuitLine call center), 1400 Jackson Street, Denver, Colorado, 80206.

The PURPOSE of this release is to request that National Jewish Medical and Research Center make an initial phone call to me to discuss participation in the Colorado QuitLine Program. I understand the information to be released, the purpose of this release, and that there are laws protecting confidentiality of information. I understand that once released, my information may be re-disclosed, and may no longer be protected. I understand that signing this form is not a condition of receiving services.

Sign Here _____
Participant Signature _____ *Date* _____

This patient may use nicotine replacement therapy.

Sign Here _____
Provider Signature _____ *Date* _____

For more NRT program information please go to <http://www.steppcolorado.com> or call 1.800.QUIT.NOW.

PLEASE FAX OR MAIL THIS SIGNED FORM TO:

Colorado QuitLine Specialist

Fax 1.800.261.6259

Mail Colorado QuitLine

National Jewish Medical and Research Center

1400 Jackson St., M305

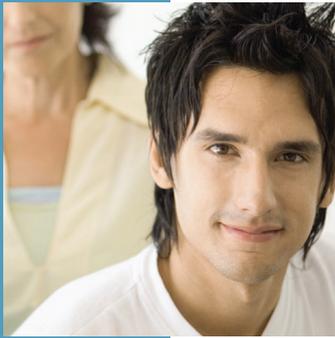
Denver, CO 80206



Smoking Cessation Treatment for Persons with Mental Illnesses

- 1 Key Findings
- 2 Components of Successful Intensive Intervention Programs
- 3 Behavioral Interventions for Smoking Cessation:
 - Overview
 - SANE Program
 - More Elements of Successful Counseling
- 4 Prescribing Cessation Medications:
 - Depression
 - Schizophrenia
 - Bipolar Disorder

Smoking cessation treatment for persons with mental illnesses



Key findings

Smoking cessation models for persons with mental illnesses generally combine nicotine replacement therapy (NRT) with Cognitive Behavioral Therapy (CBT), a type of psychotherapy that focuses on changing dysfunctional thoughts, emotions and behavior.

CBT programs that produce the most successful quit rates for the mental health population generally have groups of approximately 8-10 individuals that meet once a week for 7-10 weeks.

Consumers with schizophrenia seem to have the highest success when CBT is combined with NRT and strategies to enhance motivation. A randomized control study by Baker et al. (2006) found that at all follow-up periods, a significantly higher proportion of smokers with a psychotic disorder who completed all treatment sessions were currently abstinent, relative to a comparison group of persons receiving care as usual, (point prevalence rates: 3 months, 30.0% vs. 6.0 %; 6 months, 18.6% vs. 4.0%; 12 months 18.6% vs 6.6%). Smokers who completed all eight treatment sessions were also more likely to have achieved continuous abstinence at three months (21.4% vs. 4.0%).

There is a strong dose-response relation between the session length of person-to-person contact and successful treatment outcomes. Intensive interventions are more effective than less intensive interventions and should be used whenever possible.

Haug et al. (2005) found that for people with depression, smoking cessation was best predicted by stage of change, with those in preparation entering treatment more quickly than contemplators or precontemplators. The variables most associated with accepting treatment were not severity of symptoms, but rather current use of psychiatric medications and perceived ability to succeed in quitting.

Components of Successful Intensive Intervention Programs:

Intensive cessation interventions should include the following (from the U.S. Department of Health and Human Services, 2000):

Assessment

Assessments should ensure that tobacco users are willing to make a quit attempt using an intensive treatment program. Other assessments can provide information useful in counseling (e.g. stress level, presence of psychiatric symptoms, stressors, other comorbidity). Persons with mental illnesses who are attempting to quit smoking should be carefully assessed and monitored for depression and other psychiatric symptoms at every office visit.

Program clinicians

Multiple types of clinicians are effective and should be used. One counseling strategy would be to have a medical/healthcare clinician deliver messages about health risks and benefits and deliver pharmacotherapy, and behavioral health clinicians deliver additional psychosocial or behavioral interventions like cognitive behavioral therapy (CBT).

Program intensity

Because of evidence of a strong dose-response relationship, the intensity of the program should be:

- Session length – longer than 10 minutes.
- Number of sessions – 4 or more.
- Total contact time – longer than 30 minutes.

Program format

Either individual or group counseling may be used. Proactive telephone counseling also is effective. Use of adjuvant self-help material is optional. Follow-up assessment intervention procedures should be used.

Type of counseling and behavioral therapies

Counseling and behavioral therapies should involve practical counseling (problem solving/skills training), as well as intra-treatment and extra-treatment social support.

Pharmacotherapy

Every smoker should be encouraged to use pharmacotherapies, except in the presence of special circumstances. Special consideration should be given before using pharmacotherapy with selected populations (e.g. pregnancy, adolescents). The clinician should explain how these medications increase smoking cessation success and reduce withdrawal symptoms. The first-line pharmacotherapy agents include: bupropion SR, nicotine gum, nicotine inhaler, nicotine nasal spray and the nicotine patch. (See Pharmacotherapies Section on p. 19 and laminated sheet at back of this manual).

Behavioral Interventions for Smoking Cessation

Use of brief psychosocial interventions, self-help and supportive therapy have been shown to be effective with general medical patients but may not be sufficient for consumers with psychiatric problems (APA, 1996). Additionally, people with mental illnesses often have fewer social supports and coping skills. Therefore, intensive behavioral therapy should be considered for these people even in the early quit attempts. When possible, the mental health provider should elicit consumer preferences about group or individual therapy. If a consumer has a specific issue that might undermine tobacco cessation (e.g. problems with assertiveness), the mental health provider might work on this issue in individual therapy while the consumer also attends group therapy for tobacco cessation.

Cessation programs for people with mental illnesses include about 7-10 sessions. Typically, there is

- an introduction to tobacco history and prevalence of use
- education about the properties of nicotine, health effects of nicotine and addictive nature of nicotine
- a review of the reasons why people smoke
- education about ways one can quit smoking, use of medication and development of a quit plan.

As noted above, additional sessions are useful for addressing issues that are pertinent to persons with mental illnesses (i.e., developing coping skills for stress and anxiety).

The SANE program in Australia (Strasser, 2001) is one effective group counseling program for persons with schizophrenia. It involves teaching problem solving skills and cognitive-behavioral techniques to aid smoking reduction and cessation maintenance. The group consists of 10 sessions, run by two trained facilitators. The content consists of the following:

- Introduction to the Program
- Reasons to Quit
- Benefits of Quitting
- Understanding Why We Smoke and Ways of Quitting
- Withdrawal Symptoms
- Social Support
- Dealing with Stress and Anxiety
- Coping with Depression
- Assertiveness Training
- Anger Management
- Smoke-Free Lifestyle
- Dealing with High Risk Situations

More Elements of Successful Counseling

Further elements of successful counseling and supportive interventions are outlined in the following tables (U.S. Department of Health and Human Services, 2000).

Common elements of practical counseling

Practical counseling treatment component (problems solving/skills training)	Examples
Recognize danger situations: Identify events, stressors, internal states or activities that increase the risk of smoking or relapse.	Negative mood Psychiatric symptoms Being around other smokers Drinking alcohol or using drugs Experiencing urges Being under time pressure
Develop coping skills: Identify and practice coping or problem solving skills.	Learning to anticipate and avoid temptation. Learning cognitive strategies that will reduce negative moods. Accomplishing lifestyle changes that reduce stress, improve quality of life or produce pleasure. Learning cognitive and behavioral activities to cope with smoking urges (e.g. distracting attention).
Provide basic information about smoking and successful quitting.	Any smoking (even a single puff) increases the likelihood of a full relapse. Withdrawal typically peaks within 1-3 weeks after quitting. Withdrawal symptoms include negative mood, urges to smoke and difficulty concentrating. Information on the addictive nature of smoking.

Additionally, staff and peer support are key factors in cessation counseling. Some common elements of each:

Supportive treatment component	Examples
Encourage the patient in the quit attempt.	Share that effective tobacco dependence treatments are now available. Note that one-half of all people who have ever smoked have now quit. Communicate belief in the consumer's ability to quit.
Communicate caring and concern.	Ask how the consumer feels about quitting. Directly express concern and willingness to help. Be open to the consumer's expression of fears of quitting, difficulties experienced and ambivalent feelings.
Encourage the consumer to talk about the quitting process.	Ask about: Reasons the consumer wants to quit. Concerns or worries about quitting. Success the consumer has achieved. Difficulties encountered while quitting.

Common elements of eliciting peer support and other resources

Supportive treatment component	Examples
Train consumers in support solicitation skills.	Show videotapes that model skills. Practice requesting social support from family, friends and coworkers. Aid consumer in establishing a smoke-free home.
Prompt support seeking.	Help consumer identify supportive others. Call the consumer to remind him or her to seek support. Inform consumers of community resources such as quitlines.
Arrange outside support.	Mail letters to supportive others. Call supportive others. Invite others to cessation sessions. Assign consumers to be “buddies” for one another.

Prescribing Cessation Medications

Utilize the frequency of mental health treatment visits as an opportunity for monitoring progress in smoking cessation. Additionally, smoking cessation strategies should be integrated and coordinated with treatments for mental illnesses.

Since people with mental illnesses appear to have more withdrawal symptoms when they stop smoking than the general population, the use of nicotine replacement therapy (NRT) even in early cessation attempts is recommended.

The optimal duration of NRT is not known. Some individuals appear to require long-term use of NRT (e.g., ≥ 6 months), but almost all individuals eventually stop using NRT and the development of dependence on NRT is rare. Thus, patient preference should be the major determinate for the duration of NRT (*American Psychiatric Association Practice Guidelines 2006: Treatment of Patients with Substance Use Disorders*, 2nd Edition, p 54).

Clinicians should closely monitor actions or side effects of psychiatric medications in smokers making quit attempts.

Depression

Consider bupropion and nortriptyline for consumers with diagnoses of depression. Bupropion-SR has been demonstrated to be the most effective in depressed patients. Patients who use bupropion-SR during a smoking cessation program are more likely to be abstinent at the quit date. However, relapse is high following the discontinuation of treatment (Evins, et al., 2005; George, et al., 2002). Additionally, bupropion-SR has had adverse affects on patients with bipolar disorder and/or a history of eating disorders. It should not be used in these populations (McNeill, 2004). Additional research on smokers with a history of depression suggests the usefulness of the nicotine transdermal patch (Thorsteinsson et al., 2001) and nicotine gum (Kinnunen et al., 1996) for short-term smoking cessation.

Strongly consider behavioral therapies such as Cognitive Behavioral Therapy (CBT), as smokers with depression are likely to fail with more minimal interventions (Brown et al, 2001). Improved cessation outcomes with the addition of CBT have been reported for nortriptyline and nicotine gum (Hall et al., 1998, 1994).

Schizophrenia

Smoking cessation programs that use the nicotine transdermal patch (NTP) demonstrate the highest quit rates for patients with schizophrenia (Williams & Hughes, 2003) as it aids in withdrawal symptoms. When treatment includes the use of NRT in patients with schizophrenia, Dalack et al. (1999) found that dyskinesias decreased during abstinence in the placebo patch condition, but increased during abstinence in the active patch condition.

NRT is associated with smoking cessation rates of 27 percent to 42 percent in smokers with schizophrenia (Addington et al., 1998; Chou et al., 2004; George et al., 2000). Also, use of nicotine nasal spray, which produces the higher plasma levels of nicotine, is associated with the reduction of withdrawal and craving (Williams et al., 2004).

In controlled trials, pharmacological treatment with sustained-release (SR) bupropion has been efficacious in promoting abstinence in persons with schizophrenia. Treatment-seeking smokers have shown success (with short-term abstinence rates of 11 percent to 50 percent) with a combination of bupropion SR and cognitive-behavioral therapy (CBT) at both the 150 mg/day (Evins et al., 2001) and the 300 mg/day doses (Evins et al., 2005; George et al., 2002). Bupropion treatment also seems to reduce the negative symptoms of schizophrenia (Weinberger et al., 2006).

Patients treated with atypical antipsychotic agents, such as clozapine (Clozaril), smoke less (George et al., 1995; McEvoy et al., 1999, 1995) and have an easier time quitting (George et al., 2002, 2000) than those treated with typical antipsychotic medications. However, smoking cessation can cause a change in plasma concentrations of psychotropic agents due to a decrease in the induction of cytochrome P450 1A2 (Weinberger et al. 2006). Antipsychotic medications whose metabolism is affected by smoking include: clozapine (Clozaril), fluphenazine

(Modecate), haloperidol (Haldol), and olanzapine (Zyprexa). Therefore, monitoring medication side effects may be needed during the first month after quitting (Kalman et al., in press; Ziedonis and George, 1997). The metabolism of risperidone (Risperdal) and quetiapine (Seroquel) does not appear to be affected by smoking (Strasser, 2001).

Bipolar Disorder

Glassman et al. (1993) found that persons with bipolar disorder (BD) may also be at risk for recurrence of depressive symptoms during smoking cessation. Interestingly, persons with BD show a genetic linkage to the $\alpha 7$ nAChR nicotinic receptor locus on chromosome 15 similar to that found for persons with schizophrenia (Leonard et al., 2001). To date, there have been no empirically based treatments published for smokers with BD (Weinberger, et al, 2006). Use of NTP is suggested for this population.

Anxiety Disorders

Although patients report that smoking reduces depression and anxiety, chronic nicotine use in animal studies is positively correlated with increased anxiety (Irvine et al. 2001). It is unclear to what extent smokers experience withdrawal symptoms and misinterpret a reduction in nicotine withdrawal as anxiety relief (Ziedonis and Williams, 2003). Cinciripini and colleagues (1995) found that smokers with high levels of trait anxiety receiving buspirone (BuSpar) versus placebo were more likely to have remained abstinent at the end of the trial but not at follow-up. As noted by Weinberger et al., (2006), a placebo-controlled study by Hertzberg et al. (2001) of bupropion SR for smokers with posttraumatic stress disorder (PTSD) found that bupropion was well tolerated and resulted in higher rates of smoking cessation (60 percent) as compared to the placebo (20 percent).

Also, in a study of veterans with post-traumatic stress disorder who were smokers McFall and colleagues (2005) found that smokers who received tobacco treatment integrated with their psychiatric care were five times more likely than smokers who received separate treatment to report abstinence from smoking nine months after the study. The smokers receiving the integrated treatment were more likely to use NRT and to receive more smoking cessation sessions. Additionally, cognitive behavioral therapy techniques that incorporate cognitive restructuring and exposure therapy to help persons learn to tolerate and become more comfortable with physical sensations may be helpful to persons with anxiety disorders (Morissette et al., 2007).

Substance Use Disorders

Not surprisingly, concurrent use of alcohol and/or other drugs is a negative predictor of smoking cessation outcomes during smoking cessation treatment (Hughes, 1996). Long-term quit rates of smokers in early recover from substance use disorders (SUDs) are low, at approximately 12 percent (Kalman, 1998; Sussman, 2002). However, persons with a past history of alcoholism do not differ significantly from control subjects in tobacco treatment outcomes (Hayford et al., 1999).

The combined effects of co-occurring substance abuse and smoking behaviors appear to significantly influence the high rates of smoking cessation treatment failure (Weinberger et al., 2006). There are few studies of pharmacotherapeutic interventions for smoking in substance abusers, but some evidence exists suggesting that nicotine replacement and behavioral approaches are effective (Burling et al., 1996; Shoptaw et al., 1996). A review of tobacco cessation studies by el-Guebaly et al. (2002) found that quit rates ranged from seven percent to 60 percent after treatment and from 13 percent to 27 percent at 12 months. To date, there are no

published controlled studies using bupropion SR in smokers with co-occurring SUDs, although these studies are in progress (Weinberger et al. 2006).

The timing of smoking cessation treatment for substance abusers remains controversial (Weinberger et al, 2006). Some studies found that concurrent treatment for smoking and other drugs appears not to be associated with increased use of alcohol or other drugs (Burling et al., 2001; Kalman et al., 2004, 2001). Joseph et al. (2004) found that while patients in alcohol treatment are interested in smoking cessation, participate in treatment, and demonstrate success, they did not show any benefit from concurrent tobacco cessation treatment. In fact, Joseph et al. found that drinking outcomes were worse with concurrent tobacco treatment, suggesting that tobacco cessation interventions should be provided to patients after intensive alcohol treatment has been completed.

Relapse Prevention

- 1 Components of Minimal Practice
Relapse Prevention
- 2 Components of Prescriptive
Relapse Prevention

Relapse prevention



Most relapses occur soon after a person quits smoking, yet some people relapse months or even years after the quit date. Relapse prevention programs can take the form of either minimal (brief) or prescriptive (more intensive) programs.

Components of Minimal Practice Relapse Prevention

These interventions should be part of every encounter with a consumer who has quit recently. Congratulate every ex-tobacco user undergoing relapse prevention on any success. Strongly encourage them to remain abstinent. When encountering a recent quitter, use open-ended questions designed to initiate consumer problem solving such as “How has stopping tobacco use helped you?” Encourage the consumer’s active discussion of the topics below:

- The benefits, including potential health benefits that the consumer may derive from cessation.
- Any success the consumer has had in quitting (duration of abstinence, reduction in withdrawal, etc.).
- The problems encountered or threats anticipated to maintaining abstinence (e.g., depression, weight gain, alcohol and other tobacco users in the household).

Components of Prescriptive Relapse Prevention

During prescriptive relapse prevention, a consumer might identify a problem that threatens his or her abstinence. Specific problems likely to be reported by consumers and potential responses follow:

Lack of support for cessation

- Schedule follow-up visits or telephone calls with the consumer.
- Help the consumer identify sources of support within his or her environment.
- Refer the consumer to an appropriate organization that offers cessation counseling or support.

Local and National Tobacco Cessation Resources

Local and national tobacco cessation resources



STEPP Healthcare Provider Web Site

<http://www.cohealthproviders.com>

STEPP

<http://www.steppcolorado.com>

American Cancer Society

<http://www.cancer.org>

American Heart Association Of Colorado

<http://www.americanheart.org>

American Lung Association of Colorado

<http://www.alacolo.org/>

American Public Health Association

<http://www.apha.org/>

Centers for Disease Control and Prevention

<http://www.cdc.gov/tobacco>

Colorado Clinical Guidelines Collaborative

<http://www.coloradoguidelines.org/>

Colorado Tobacco Education and Prevention Alliance

<http://www.ctepa.org/>

Society for Research on Nicotine and Tobacco

<http://www.srnt.org>

Surgeon General

<http://www.surgeongeneral.gov/>

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Toolkit references



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Literature review

Individual Studies

Yr of Pub	Author	Article Name	Volume # / Issue #	Intervention	Results	Setting/ Contact Type
2001	Acton, G., Prochaska, J., et al.	Depression and stages of change for smoking in psychiatric outpatients	Addictive Behaviors, 26(5)	Correlational study: 205 psychiatric outpatients completed measures of depression (PRIME-MD and BDI-II)	Patients who had never smoked showed lower rates of MDD than those who had smoked; patients in early stages of change did not show more MDD or depressive symptoms, but showed more negative thoughts about abstinence; suggest building smoking cessation interventions based on the transtheoretical model of change for use w/ psychiatric pops.	Outpatient psychiatric research center; Survey
1998	Addington, J., el-Guebaly, N., et al.	Smoking cessation treatment for patients with schizophrenia	American J of Psychiatry, 155(7)	50 schizophrenic outpatients were divided into 5 groups who met for 7 weekly smoking cessation program sessions	42% of patients had stopped smoking at the end of the group sessions, 16% remained abstinent at 3 mo, and 12% at 6 mo.; no changes in either pos or neg symptoms of schizophrenia.	Outpatient psychiatric research center; Face to face
2006	Baker, A., Richmond, R., Haile, M., et al.	A randomized controlled trial of a smoking cessation intervention among people with a psychotic disorder	American J of Psychiatry, 163(111)	298 regular smokers with a psychotic disorder were randomly assigned to a treatment condition consisting of 8 individual one hour sessions of motivational interviewing and cognitive behavioral therapy or control (treatment as usual)	A significantly higher proportion of smokers who completed all treatment sessions stopped smoking at each of the follow-up times than controls (point prevalence rates at 3 months: 30% vs 6%; 6 months: 18.6% vs 4%; 12 months 18.6% vs 4%).	Outpatient mental health clinics or research center; Face to face
1996	Borrelli, B., Niaura, R., et al.	Development of MDD during smoking-cessation treatment	J of Clinical Psychiatry, 57(11)	144 non-depressed Ss took the BDI and the Hamilton Rating Scale for Depression; tx was fluoxetine	5 Ss met threshold criteria for MDD.	Face to face
2001	Brown, R., Kahler, C., Niaura, R., et al.	Cognitive-behavioral treatment for depression in smoking cessation	J of Consulting & Clinical Psych, 69	Smokers w/ MDD randomized to standard CBT smoking cessation tx or smoking cessation tx + CBT treatment for depression	Smoker with recurrent MDD and heavy smokers who received CBT-D were significantly more likely to be abstinent than in standard treatment.	Face to face
2000	Combs, D. & Advokat, C.	Antipsychotic medication and smoking prevalence in acutely hospitalized patients with chronic schizophrenia	Schizophrenia Research, 46(2-3)	Schizophrenic patients who smoked and were either receiving a typical antipsychotic (n=15), clozapine (n=6), or another atypical antipsychotic (n=18)	Clozapine was associated with a significantly lower incidence of smoking than either typical drugs or other atypical antipsychotics.	Inpatient; Face to face

Yr of Pub	Author	Article Name	Volume # / Issue #	Intervention	Results	Setting/ Contact Type
1990	Covey, L, Glassman, A, et al.	Depression and depressive symptoms in smoking cessation	Comprehensive Psychiatry, 31(4)	Investigation into results of a behaviorally oriented smoking cessation program showed smokers w/ MDD history had lower success rates	First week – frequency and intensity of psychological symptoms, particularly depressive mood, were higher among smokers with past depression; interventions should attempt to prevent dysphoric symptoms during acute withdrawal period for MDD smokers.	Face to face
2002	Covey, L, Glassman, A, et al.	A randomized trial of sertraline as a cessation aid for smokers with a history of major depression	American J of Psychiatry, 159(10)	134 smokers with history of MDD received Sertraline (n=68) or matching placebo (n=66) 1 wk placebo washout, 9 wk double-blind, placebo-controlled treatment phase followed by a 9 day taper period, and a 6 mo. drug free follow-up; all received intensive individual cessation counseling during 9 clinic visits	Sertraline tx produced a lower total withdrawal symptom score and less irritability, anxiety, craving, and restlessness than placebo; however no significant difference between the groups.	Face to face
1999	Dalack, G., Becks, L., et al.	Nicotine withdrawal and psychiatric symptoms in cigarette smokers with schizophrenia	Neuropsychopharmacology, 21(2)	19 outpatients w/ schizophrenia or schizoaffective disorder; 1 day of ad libitum smoking followed by 3 days of acute smoking abstinence while wearing 22 mg/day active or placebo transdermal nicotine patches, with a return to 3 days of smoking between patch conditions	Dyskinesias were found to have decreased during abstinence and placebo patch treatment, but increased during abstinence and the active patch conditions.	Outpatient psychiatric research center; Face to face
2005	Evins, A., Cather, C., et al.	A double-blind placebo-controlled trial of bupropion sustained-release for smoking cessation in schizophrenia	J of Clinical Psycho-pharmacology, 25(3)	bupropion-SR vs placebo; and CBT	Ss in bupropion grp were more likely to be abstinent for the week after the quit date and at the end of the intervention; Ss in the bupropion grp had a higher rate of 4-wk continuous abstinence (wks 8-12) and a longer duration of abstinence; relapse is high following the discontinuation.	Recruited from community mental health centers; Face to face
2004	Evins, A., Rigotti, C., et al.	Two-year follow-up of a smoking cessation trial in patients with schizophrenia: Increased rates of smoking cessation and reduction	Clinical Psychiatry, 65(3)	2 yr follow-up to bupropion tx w/ CBT	More Ss were abstinent at follow up than were abstinent at the end of the trial; decreased smoking during the trial was predictive of later smoking reduction.	Face to face

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1995	George, T., Sernyak, M., et al.	Effects of clozapine on smoking in chronic schizophrenic outpatients	J of Clinical Psychiatry, 56(8)	29 schizophrenic outpatients; clozapine tx vs TYP neuroleptics	There was a sig decrease in reported daily cig use after clozapine tx.	Face to face
2002	George, T., Vessicchio, J., et al.	A placebo controlled trial of bupropion for smoking cessation in schizophrenia	Biological Psychiatry, 52(1)	bupropion-SR vs placebo	Bupropion-SR increased smoking abstinence rates; pos symp – not affected, neg symp reduced; ATYP use enhance smoking cessation responses to BUP.	Face to face
2000	George, T., Ziedonis, D., et al.	Nicotine transdermal patch and atypical antipsychotic medications for smoking cessation in schizophrenia	American J of Psychiatry, 157(11)	Ss w/ schizo or schizoaff treated w/ NTP & w/ either ATYP or TYP antipsychotics; GT of the Amer Lung Assn or GT for smokers w/ schizo that emphasized motivation enhancement, relapse prevention, social skills training, and psychoeducation	Effects of NTP are modest in schizophrenic patients; no difference in GT programs; ATYP may be superior to TYP in combination w/NTP for smoking cessation in schizophrenic patients.	Face to face
1997	Ginsburg, J., Klesges, R., et al.	The relationship between a history of depression and adherence to a multi-component smoking-cessation program	Addictive Behaviors, 22(6)	13 wk CBG & random assignment to nicotine gum, appetite suppressant gum, or placebo gum	Group CBT is an effective smoking-cessation program for women with a history of depression who are not currently depressed.	Face to face
1993	Glassman, A., Covey, L., et al.	Smoking cessation, clonidine, and vulnerability to nicotine among dependent smokers	Clinical Pharmacology & Therapeutics, 54(6)	Clonidine	MDD predict tx failure; an increased risk for psychiatric complications after smoking cessation was apparent among smoker with MDD, particularly bipolar.	Face to face
1991	Greeman, M. & McClellan, T.	Negative effects of a smoke-free rule on an inpatient psychiatry service	Hospital & Community, 42(4)	Smoking ban on inpatient units at a Veterans Affairs medical center	20-25% of patients who smoked had difficulty adjusting to the rule, and some patients experienced major disruption in their tx.	Inpatient; Face to face
2004	Haas, A., Munoz, R., et al.	Influences of mood, depression history, and treatment modality on outcomes in smoking cessation	J Consult Clin Psychol, 72(4)	549 Ss (28% w/ history of MDD); CBT vs. HE	MDD-R Ss had higher rates of abstinence in CBT compared w/ HE, even when the contribution of mood and the interaction between mood and an MDD x tx variable were included in the model.	Face to face

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1994	Hall, S.M., Reus, V.I., Munoz R.F., et al	Cognitive-behavioral intervention increases abstinence rates for depressive-history smokers	J Consult Clin Psychol, 62(1)	149 smokers (31% had a history of MDD); all received 2 mg/day of nicotine gum; MM provided in 10 group sessions over 8 wks; standard tx provided in 5 gp sessions over 8 wks	Ss w/ MDD were more likely to be abstinent when treated w/ MM, and less anger at baseline was predictive of abstinence.	Face to face
1998	Hall, S.M., Reus, V.I., Munoz R.F., et al	Nortriptyline and CBT in the treatment of cigarette smoking	Archives Gen Psych, 55	Hx of MDD vs. No hx of MDD randomized to Nortriptyline vs. placebo and CBT vs. control	Nortriptyline- higher abstinence rates than placebo, independent of depression hx. CBT- More effective for + hx MDD. Smokers with hx of depression are aided by more intensive psychosocial treatments.	Face to face
1996	Hall, S.M., Reus, V.I., Munoz R.F., et al	Mood management and nicotine gum in smoking treatment: A therapeutic contact and placebo-controlled study	J of Consulting & Clinical Psych, 64(5)	Mood management (MM) vs. contact-equivalent health education (HE); and 2 mg to 0 mg of nicotine gum for smokers w/ history of MDD	MM and HE produced similar abstinence rates: 2 mg gum was no more effective than placebo; MDD patients had a greater increase in mood disturbance after the quit attempt; MDD patients may be best treated by interventions providing additional support and contact, independent of therapeutic contact.	Face to face
2005	Haug, N.A., Hall, S.M., Prochaska, J.J. et al.	Acceptance of nicotine dependence treatment among currently depressed smokers	Nicotine & Tobacco Research, 7 (2), (April 2005) 217-224	This study reports on baseline characteristics associated with acceptance and refusal of available smoking treatment among currently depressed smokers in a psychiatric outpatient clinic. The sample (N=5154) was 68% female and 72% White, with a mean age of 41.4 years and average smoking rate of 17 cigarettes/day. All participants were assigned to a repeated contact experimental condition; received a stage-based expert system program to facilitate treatment acceptance; and were then offered smoking treatment, consisting of behavioral counseling, nicotine patch, and bupropion	The number of days to treatment acceptance was significantly predicted by stage of change, with those in preparation entering treatment more quickly than contemplators or precontemplators. In a logistic regression, the variables most strongly associated with accepting treatment were current use of psychiatric medication and perceived success for quitting. Severity of depressive symptoms, duration of depression history, and history of recurrent depression were not related to treatment acceptance. Findings have implications for the psychiatric assessment and treatment of smokers in clinical settings. Psychiatric medication may play a significant role in smoking cessation treatment acceptance by currently depressed smokers.	Outpatient psychiatric research center; Self-report and structured interview measures

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1999	Hayford, K., Patten, C., et al.	Efficacy of bupropion for smoking cessation in smokers with a former history of major depression or alcoholism	British J of Psychiatry, 174	615 smokers received placebo or bupropion-SR at 100, 150, or 300 mg/day for 6 wks after target quit date	Dose response effect of tx for smoking cessation was found.	Face to face
2000	Keuthen, N., Niaura, R., et al.	Comorbidity, smoking behavior and treatment outcome	Psychotherapy & Psychosomatics, 69 (5)	120 smokers; 10 wk smoking cessation trial w/fluoxetine & behavioral tx; 62.3% of Ss were diagnosed with a lifetime mood, anxiety or SUD	Lifetime comorbidity was related to higher smoking rates and nicotine dependence, depressed mood and greater self report of anxiety and stress. Baseline scores on the BDI were related to tx outcome for Ss w/o positive history of any psychiatric disorder, with lower BDI scores more freq in those who were abstinent.	Face to face
2000	Lucksted, A., Dixon, L., et al.	A focus group pilot study of tobacco smoking among psychosocial rehabilitation clients	Psychiatric Services, 51(12)	5 focus groups (6-10 Ss each) 40 clients in psychosocial rehabilitation programs. Discussed pros and cons of smoking and not smoking.	Results indicate that issues and needs that are specific to smokers who use mental health services must be addressed in the development of smoking prevention and cessation interventions in psychosocial rehabilitation and other mental health programs.	Face to face
1997	Martin, J.E., Calfas, K.J., Patten CA, et al.	Prospective evaluation of three smoking interventions in 205 recovering alcoholics: One-year results of Project SCRAP-Tobacco	J of Consulting & Clinical Psych, 65(1)	Randomized: standard treatment (ALA quit program + nicotine anonymous meetings) (ST), behavioral counseling + exercise (BEX), or behavioral counseling plus nicotine gum (BNIC)	BEX= significantly higher quit rates at post-treatment, not at 6 or 12 months.	Face to face
2002	Niaura, R., Spring, B., Borelli, B., et al.	Multicenter trial of fluoxetine as an adjunct to behavioral smoking cessation treatment	J of Consulting & Clinical Psych, 70(4)	Randomized to 3 dose conditions: 10 weeks of placebo, 30 mg, or 60 mg fluoxetine plus 9 weeks CBT	Analyses assuming missing data = smoking observed no treatment difference in outcomes. Pattern-mixture analysis that estimates treatment effects in the presence of missing data = enhanced quit rates associated with both the 60-mg and 30-mg doses.	Face to face
1998	Patten, C.A., Martin, J.E., Meyers, M.G., et al.	Effectiveness of cognitive-behavioral therapy for smokers with histories of alcohol dependence and depression	J of Studies on Alcohol, 50(3)	Randomized: behavioral counseling (BC) or BC+ CBT	Significantly more smokers in CBT quit at post-treatment and 12 month followup.	Face to face

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2000	Patten, C.A., Martin, J.E., Calfas, K.J., et al.	Brief report effect of three smoking cessation treatments on nicotine withdrawal in 141 abstinent alcoholic smokers	Addictive Behaviors 25(2)	Randomized to 12 week program of Standard Treatment, behavioral counseling plus exercise, or behavioral counseling plus nicotine gum	No significant effect of treatment on percentage reduction in smoking rate. All 3 groups showed similar overall reductions in smoking rate.	Face to face
1997	Rabois, D., Haaga, D.	Cognitive coping, history of depression, and cigarette smoking	Addictive Behaviors, 22(6)	Tested premise that formerly depressed smokers are lacking in cognitive coping skills taught in CBT. 4 groups (depressed/not, smoker/not) completed WOR to test cognitive coping	Hx of depression associated with significantly more negative responses on WOR. "This study suggests that people with a history of depression tend to lack such skills and might therefore especially benefit from incorporation of cognitive behavior therapy principles in smoking-cessation programs."	Interview
2006	Thorndike, F.P., Friedman-Wheeler, D.G., Haaga, D.A.	Effect of cognitive behavior therapy on smokers' compensatory coping skills	Addict Behav, Jan 18	Randomized to CBT or comparison condition of education and scheduled smoking reduction. (unique to CBT condition was cognitive restructuring for mood management)	CBT group did NOT show more improvement in compensatory coping skills (measured by Ways of Responding). A nonsignificant trend favoring CBT was found in post-treatment abstinence.	Face to face
2001	Weiner, E., Ball, M.P., Summerfelt, A., et al	Effects of sustained-release bupropion and supportive group therapy on cigarette consumption in patients with schizophrenia	Am J of Psychiatry, 158	9 sessions of weekly group therapy in conjunction with open label bupropion treatment (150mg/ twice a day) for 14 weeks	None of the subjects quit smoking. However, measured change in expired breath carbon monoxide levels indicated reduction in smoking.	Outpatient psychiatric research center; Face to face
1997	Ziedonis, D.M., George, T.P.	Schizophrenia and nicotine use: Report of a pilot smoking cessation program and review of neurobiological and clinical issues	Schizophrenia Bulletin, 23(2)	24 schizophrenic patients: Nicotine replacement, motivational enhancement therapy, and relapse prevention behavioral therapy	50% completed the program, 40% decreased use by 50%, and 13% remained abstinent for 6 months.	Face to face

Review Articles

Yr of Pub	Author	Article Name	Volume # / Issue #	Conclusions/Discussion
1992	Dalack, G.W. & Glassman, A.H.	A clinical approach to help psychiatric patients with smoking cessation	Psychiatric Quarterly, 63(1)	A discussion of the interface of psychiatric illness and smoking, particularly among those chronically hospitalized in psychiatric institutions. It suggests a rational approach to help psych patients stop smoking.
1998	Dalack, G.W., Healy, D.J., et al.	Nicotine dependence in schizophrenia: Clinical phenomena and laboratory findings	American J of Psychiatry, 155(11)	Clinical data suggest that smoking in schizophrenia is an attempt to self-medicate (negative) symptoms. Knowledge on the effects of nicotine on schizo patients may lead to new treatment for both dx and tx.
1999	Dursun, S.M. & Kutcher, S.	Smoking, nicotine and psychiatric disorders: evidence for therapeutic role, controversies and implications for future research	Medical Hypotheses, 52(2)	Investigated three components of the social-scientific-ethical dilemma that researchers looking into the possible therapeutic effects and the mechanisms of action of nicotine in neuropsychiatric disorders.
2002	el-Guebaly, N. & Cathcart, J.	Smoking cessation approaches for persons with mental illness or addictive disorders	Psychiatric Services, 53(9)	Review of 24 empirical studies of outcomes of smoking cessation approaches used with samples of persons with mental disorders. Found that the majority of interventions combined medication and psychoeducation.
1995	Hughes, J.R. & Frances, R.J.	How to help psychiatric patients stop smoking	Psychiatric Services, 46(5)	
2003	Martinez-Raga, J. & Keaney, F.	Treatment of nicotine dependence with bupropion SR: Review of its efficacy, safety and pharmacological profile	Addict Biol, 8(1)	This article found that bupropion SR appears to be a safe, well-tolerated and effective medication in combination with smoking cessation counselling for a wide range of smokers.
1993	Resnick, M.P.	Treating nicotine addiction in patients with psychiatric co-morbidity	Nicotine addiction: Principles and management, pp. 327-336 (eds: Orleans, C.T. & Slade, J.D.)	Explore the unique circumstances of psychiatric patients, the relationship between psychiatric disorder and nicotine addiction, and special problems in psychiatric institutions/ recent research on the interaction between smoking cessation, relapse, and mood disorder is reviewed/ discusses interaction between psychotropic medications and smoking.
2001	Ziedonis, D., Krejci, J., et al.	Integrated treatment of alcohol, tobacco, and other drug addictions	Integrated treatment of psychiatric disorders (ed: Kay, J.) Review of psychiatry, 20(2)	Empirical literature on the effectiveness of combined treatment of specific substance use disorders. Review of 3 of the leading psychotherapies currently in use in the treatment of patients with substance abuse disorders: 12-step, motivational enhancement therapy, and relapse prevention.
1998	Ziedonis, D.M., Wyatt, S.A., et al.	Current issues in nicotine dependence and treatment	New treatments for chemical addictions (eds: McCance-Katz, E.F. & Kosten, T.R.) Review of psychiatry series.	Pharmacotherapies can be integrated with behavioral management techniques that are individualized to the needs of the patient.



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These materials are funded with proceeds from Colorado's tobacco tax.